NEW HAMPSHIRE VETERANS HOME (NHVH)
APPLICATION FOR ADMISSION INSTRUCTIONS/CHECKLIST

The applicant must meet the following criteria to be eligible to apply for admission:

1. Honorably discharged from active duty service from the armed forces or reserve or National Guard
2. Residing in NH for one year immediately preceding the date of application **OR** home of record on military discharge document is listed as NH
3. Financial requirements are met (see list of required documents below and Financial Cost Information page 3 for details)
4. The applicant's condition(s) are within the NHVH's resources and ability to treat (as determined by our medical director and Admissions Committee review), and the applicant does not present potential harm to self or others

The applicant completes and signs the application forms. If a physician has certified that the veteran lacks the capacity to make medical decisions, and there is an activated Durable Power of Attorney for Healthcare or a Guardian over person in effect, that person may complete and sign the paperwork.

The following forms and documents MUST be received with the initial application.

- ☐ Admission Application Form, page 1 and Legal/Contact Information page1A
- ☐ Financial Affidavit for Applicant, page 3A
- ☐ Agreement Form, page 4
- ☐ Criminal Record Release Authorization Form (Please note two signatures are required and must be witnessed by a notary. There is no fee if we submit the form. We must have the original, not a copy.)
- ☐ DD-214 or other discharge papers (with service number, entry/discharge dates and type of discharge)
- ☐ Copies of any advance directives (Durable Power of Attorney for Healthcare and/or Finance, Living Will, Guardianship over person and/or estate, Do Not Resuscitate form, anatomical gift form)
- ☐ Copy of marriage certificate/civil union contract **OR** divorce decree **OR** death certificate for applicant's spouse (we need only the most recent document)
- ☐ The past 12 months of statements for any bank accounts or investments in applicant's **AND/OR** spouse's name, including **images of cancelled checks** (these may be part of the statements or can be obtained from the bank)
- ☐ Copy of any trust documents or long-term care policies
- ☐ Copy most recent tax bill for any property in applicant's **AND/OR** spouse's name
- ☐ Copy of service-connected disability or VA pension approval letter
- ☐ Front and back copies of all health insurance cards, including Medicare
- ☐ Copy of applicant's Social Security card
- ☐ The current year's notification letter showing recurring income amounts for Social Security and any other retirement for applicant

The applicant's primary doctor/ARNP needs to complete and sign the VA Form 10-10SH and 5B, arrange required testing (chest x-ray, complete blood count, urinalysis, and tuberculosis test), and send results to the NHVH Admissions office. If testing has been done in the past 3 months and shows no disease, those results may be sent. Forms and tests **must be done as part of the approval process**, and **both tuberculosis test AND chest x-ray are required.** Please give your primary care provider the following pages:

- ☐ Instructions to Physician/ARNP, page 5, and
- ☐ The VA Form 10-10SH and Medical Information Form, page 5B

Other documentation to be included with your completed application:

- ☐ Final Requests, page 2
- ☐ Three (3) Release of Information, page 6
- ☐ Consent to Treatment, Use of Health Care Information, and Receipt of Notice of Privacy Practices, page 7 (note: please review and keep Notice of Privacy Practices) (MR number will be filled in upon admission)
- ☐ Security Form, page 8

Please send completed packet by mail, or deliver to the NHVH's Admissions Office.

New Hampshire Veterans Home | 139 Winter Street | Tilton NH 03276 | (603) 527-4400 | www.nh.gov/veterans

NEW HAMPSHIRE VETERANS HOME
ADMISSION APPLICATION

Full Name:_____ SS #: _____

Address:_____ Phone #: _____

_____

Where have you lived in the past two years? _____

DOB: _____ Place of Birth:_____ Male:☐ Female:☐

Mother's Maiden Name: _____ Religion: _____

Education Level: _____ Previous Occupations: _____

Married/Civil Union:_____Divorced:_____Widowed: ____Single:_____Separated: _____

MILITARY INFORMATION:

Branch of Service: _____

Service Connected Disability? No_____ Yes_____ What % _____

Type of Service Disability: _____

Date of Enlistment: _____ Place of Enlistment: _____

Date of Discharge: _____ Place of Discharge: _____

Rank: _____Type of Discharge: _____

Veterans Service Groups: _____Post #:_____

_____Post #:_____

MEDICAL INSURANCE INFORMATION: **(Include front & back copies of all health insurance cards)**

Medicare: Part A ☐ Part B ☐ Number:_____

Other Insurances: _____Policy #:_____

MEDICAL INFORMATION:

Primary Care Physician/APRN: _____

Address: _____

_____

Phone: _____ Fax: _____

List all providers of medical care for the past 12 months (doctors, specialists, hospitals, nursing homes)

_____

_____

_____

NEW HAMPSHIRE VETERANS HOME
LEGAL/CONTACT INFORMATION

LEGAL INFORMATION: Do you have any of the following? If so, please include copies.

	Yes	No	Name
Power of Attorney for Healthcare	☐	☐	_____
Power of Attorney for Finances	☐	☐	_____
Living Will	☐	☐	_____
Court appointed Guardian (person)	☐	☐	_____
Court appointed Guardian (estate)	☐	☐	_____
Do Not Resuscitate Form	☐	☐	
Anatomical Gift Form	☐	☐	

SPOUSE/ PARTNER TO A CIVIL UNION: (Include copies of wedding/civil union/death certificate)

Name _____ Phone Numbers:

Address _____ Home _____

_____ Work _____

Date of Birth: _____ Cell _____

SS #: _____ Date of Death (if applicable) _____

Date of Marriage or Civil Union: _____ Place: _____

1ST CONTACT PERSON: (power of attorney for healthcare if applicable)

Name _____ Phone Numbers:

Address _____ Home _____

_____ Work _____

Relationship: _____ Cell _____

2ND CONTACT PERSON: (second power of attorney for healthcare if applicable)

Name _____ Phone Numbers:

Address _____ Home _____

_____ Work _____

Relationship: _____ Cell _____

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____ _____

Witness Signature (Required) Date

NEW HAMPSHIRE VETERANS HOME
FINAL REQUESTS

Name _____ MR# _____

The following instructions direct the New Hampshire Veterans Home of my wishes in regards to final services in the event of my demise while a resident of the Home.

Name of Funeral Home: _____

Address: _____

_____

Phone Number: _____

Location of cemetery plot: _____

Purchaser's name of plot: _____

Have these arrangements been prepaid? Yes☐ No☐

Special instructions, i.e.: military funeral, private services, cremation, etc.:

_____

_____

Do you have Life Insurance? Yes☐ No☐

Do you have a will? Yes☐ No☐ If yes, where is it located? _____

- I understand that if a funeral home has not been chosen; that one must be chosen within 30 (thirty) days after admission to the New Hampshire Veterans Home. If I do not choose a funeral home, the NHVH will choose one for me.
- I understand that all personal possessions left at the Home 30 (thirty) days after my departure will be dealt with following the procedure set forth by the New Hampshire Veterans Home's Deceased and Discharged Member Belongings Policy.
- I hereby state my preference on the following items:
  - Remembrance photo: Yes☐ No☐ (upon death of a resident we will honor their memory by placing a photo with their name and dates of birth and death at the unit nurses' station for a time)
  - Final Salute participant: Yes☐ No☐ (upon death of a resident the veterans and staff of the NHVH will honor their passing with a brief military ceremony here in the Home)

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____ _____

Witness Signature (Required) Date

NEW HAMPSHIRE VETERANS HOME
FINANCIAL COST INFORMATION

The financial cost to the Veteran for residing at the New Hampshire Veterans Home is dependent on the Veteran's assets. The applicant's home is not an accountable asset if the spouse/civil union partner/ dependent child are residing in the home or if legal documents demonstrate other ownership. There is a required one year look back of all assets. Therefore, the cost of care is determined as follows:

- **With ASSETS ABOVE $30,000 :** The Veteran's room and board charges will be as a self-pay resident at a daily rate of $320.00 per day (subject to yearly change) until assets are less than $30,000.00.

- **With ASSETS less than $30,000** the Veteran's room and board charges will be based on the Veteran's **total** monthly income***** based on the following formula:

Veteran's total monthly income	=	$_____
Deduct $l00.00 (for the veteran)	-	$l00.00
New total of monthly income:	=	$_____
Multiply by	X	.90 **
This is the monthly cost to the veteran		$_____

*Monthly income represents all income received from federal, state or private companies, to include, but not limited to Social Security, retirement of any kind, interest income, annuities, VA disability/compensation check and other income sources received by the Veteran.

**The l0% difference is for personal needs, and expenses not covered.

ROOM AND BOARD CHARGES include: all VA formulary prescription medications, 24 hour nursing care, physical therapy for maintenance/restorative care only, recreational activities, transportation to and from medical appointments ordered by the NHVH MD as per NHVH transportation policy, all dietary services (three meals and snacks), daily housekeeping services, laundry services**,** incontinence products, basic cable TV, routine dental care, podiatry nurse care, management of resident account and coordination of VA/Pension benefits, social services, library services

EXPENSES NOT COVERED: Additional medical services may be required that are not covered by the room and board rate and which may or may not be covered by the VA , Medicare, or other health care insurances you may have. Other items not covered are: non- covered VA formulary brand name prescription medications, Medicare co-pay, supplemental health care insurance premiums cost, hair cuts, personal clothing, personal toiletries, eyeglasses and prescriptions, dentures/partial plates (new or repaired), hearing aids (new or repaired**),** personal cell phones, personal computers, WIFI, extra cable channels, private travel to local banks, fees for legal documents, legal services, personal snacks, out of house meals, entertainment equipment such as TVs, DVDs, CDs, radios, etc. and some durable medical equipment

NEW HAMPSHIRE VETERANS HOME
FINANCIAL AFFIDAVIT FOR APPLICANT

Name: _____ SS # _____

Assets:	**Veteran**	**Spouse/Civil Union Partner**	**Joint**
Checking Accounts	$_____	$_____	$_____
Saving Accounts:	$_____	$_____	$_____
Certificates of Deposit	$_____	$_____	$_____
Investments:			
Annuities	$_____	$_____	$_____
Mutual Funds	$_____	$_____	$_____
Bonds	$_____	$_____	$_____
IRAs	$_____	$_____	$_____
Stocks	$_____	$_____	$_____
Other Ret. Benefits:	$_____	$_____	$_____
Property			
Residence (value)	$_____	$_____	$_____Mortgage/Liability
Other Real Estate	$_____	$_____	$_____Mortgage/Liability
Rental Income	$_____	$_____	$_____
Time share	$_____	$_____	$_____
Business Ownership	$_____	$_____	$_____
Loans due you	$_____	$_____	$_____

Alimony/Child Support Yes☐ No ☐ How much per month?_____

Long Term Care Insurance: Yes☐ No ☐ Rate per day?_____

Length of coverage?_____

Trusts: Yes☐ No ☐ Revocable ☐ Irrevocable ☐

Monthly Incomes:	**Veteran**	**Spouse /Civil Union Partner**
Social Security	$_____	$_____
Military Retirement	$_____	$_____
Federal, State, City Retirement	$_____	$_____
Railroad Retirement	$_____	$_____
Other Retirement	$_____	$_____
Non-Service Connected Compensation	$_____	$_____
Service Connected Compensation	$_____	$_____
Interest on Investments	$_____	$_____
Income from other sources as rental Loans due you, etc	$_____	$_____
Total Monthly Income	$_____	$_____

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐Other (please specify) _____

_____ _____

Witness Signature (Required) Date

NEW HAMPSHIRE VETERANS HOME
AGREEMENT FORM

I understand the New Hampshire Veterans Home is owned and operated by the State of New Hampshire and is therefore subject to the rules of the State.

I give permission to the New Hampshire Veterans Home to provide requested information as needed to the Department of Veterans Affairs. This includes spouse's income and Social Security number, which is required to determine VA benefits.

I agree to abide by the New Hampshire Veterans Home rules and regulations established by the Commandant, the Board of Managers and the State of New Hampshire.

I verify that the assets listed in this application are accurately stated. I verify that I have not transferred any assets in the twelve-month period prior to applying to the New Hampshire Veterans Home for the sole purpose of complying with the eligibility requirements.

I will provide proof of financial assets and monthly income during the admission process and anytime thereafter, upon request by the Business Office, to be used in determining my monthly cost of care.

I agree to accept transfer or discharge to another facility capable of providing for my needs if the New Hampshire Veterans Home does not have the resources to meet my care needs as advised by the Medical Director.

I have read, or had read to me, and understand the information provided in this application.

The information given in this admission application is true and correct to the best of my knowledge and belief. The New Hampshire Veterans Home reserves the right to request updated information regarding this application.

I certify there are no willful misrepresentations or inaccurate or untruthful answers to questions. If an investigation discloses such misrepresentations, my admission to the Home maybe denied. If I should already be a Resident, I may be discharged from the Home.

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____ _____

Witness Signature (Required) Date

NEW HAMPSHIRE VETERANS HOME
INSTRUCTIONS TO PHYSICIAN/ARNP

Name of Applicant	DOB	Social Security #

1. **Please complete VA form 10-10SH & the Medical Information Form** on behalf of our applicant who is applying to the New Hampshire Veterans Home.

2. **Please provide results of**
   a. **Chest X-Ray**
   b. **Tuberculosis Testing**
   c. **Urinalysis**
   d. **CBC**

   ALL TESTS ARE REQUIRED. Chest x-ray and tuberculosis testing must both be done.

   If tests have been done recently (in the past three months) and are negative for disease or illness, those results may be sent.

   *NOTE: If TB Test is positive, contact the Admissions Office for further instructions

3. **The Physician's or ARNP's signature is required both at the bottom of VA Form 10-10SH AND where indicated on the Medical Information Form.**

These documents can be faxed to **603-266-1266** or mailed to:

Admission Coordinators
New Hampshire Veterans Home
139 Winter Street
Tilton, NH 03276

Please call the Admission Office at 603-527-4846/527-4843 if you have any questions. Thank you.

OMB Approval No. 2900-0160
Estimated Burden: Avg. 20 min.
EXP: Feb 28, 2019

Department of Veterans Affairs

VA FORM 10-10SH
STATE HOME PROGRAM APPLICATION FOR VETERAN CARE MEDICAL CERTIFICATION

PART I - ADMINISTRATIVE

1. STATE HOME FACILITY	2. DATE ADMITTED
New Hampshire Veterans Home	

3. STATE HOME FACILITY ADDRESS (Street, City, State and Zip Code)
139 Winter Street, Tilton, NH 03276

4. RESIDENT'S NAME (Last, First, Middle) (Mandatory field)

5. SOCIAL SECURITY NUMBER (Mandatory field)	6. GENDER ☐ M ☐ F	7. AGE	8. DATE OF BIRTH (MM/DD/YYYY)	9. ADVANCED MEDICAL DIRECTIVE ☐ NO ☐ YES

10. HAS THE VETERAN PROVIDED FINANCIAL DISCLOSURE FOR PURPOSES OF DETERMINING ELIGIBILITY FOR DOMICILIARY PER DIEM PAYMENTS?
☐ YES ☐ NO ☐ N/A **10-10EZ or 10-10EZR IS REQUIRED TO BE SUBMITTED EITHER IN PAPER FORM OR ELECTRONICALLY WITH THE 10-10SH**

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

11. HISTORY

12. HEIGHT	13. WEIGHT	14. TEMP	15. PULSE	16. BP	17. HEAD/EYES/EAR/NOSE AND THROAT

18. NECK	19. CARDIOPULMONARY
29. ABDOMEN	21. GENITOURINARY
22. RECTAL	23. EXTREMITIES
24. NEUROLOGICAL	25. ALLERGY/DRUG SENSITIVITY

26. X-RAY/ LAB							
	CHEST X-RAY	DATE (MM/DD/YYYY)	RESULT	CBC	DATE (MM/DD/YYYY)	RESULT	
	SEROLOGY						
	URINALYSIS	DATE (MM/DD/YYYY)	ALBUMIN	ACETONE		SUGAR	

CHECK ALL BOXES THAT APPLY OR CHECK N/A

27. IS DEMENTIA THE PRIMARY DIAGNOSIS	28. IS THERE A DIAGNOSIS OF MENTAL ILLNESS	29. HAS RESIDENT RECEIVED MENTAL HEALTH SERVICES WITHIN THE PAST 2 YEARS	30. IS CLIENT A DANGER TO SELF OR OTHERS
☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A	☐ YES ☐ NO ☐ N/A

31. IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:
☐ SCHIZOPHRENIA ☐ PARANOIA ☐ OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY ☐ N/A
☐ MOOD SWINGS ☐ SOMATOFORM DISORDER ☐ PANIC OR SEVERE ANXIETY DISORDER ☐ PERSONALITY DISORDER

32. OXYGEN	33. FEEDING	34. WOUND	35. FOLEY CATHETER
☐ MASK ☐ PRN ☐ N/A	☐ TUBE FEEDING ☐ N/A	☐ DECUBITUS ULCERS ☐ N/A	☐ TEMPORARY ☐ N/A
☐ NASAL CANNULA ☐ CONTINUOUS	☐ OSTOMY ☐ TRACHEOSTOMY	☐ DRAINING WOUND ☐ WOUND CULTURED	☐ PERMANENT

36. REFERRING PHYSICIAN	37. PRIMARY DIAGNOSIS
38. SECONDARY DIAGNOSIS	39. TERTIARY DIAGNOSIS

40. ARE THE ADMITTING DIAGNOSIS RELATED TO A SERVICE CONNECTED CONDITION? ☐ YES ☐ NO ☐ UNKNOWN

41. TYPE OF CARE RECOMMENDED: ☒ SKILLED NURSING HOME CARE ☐ DOMICILIARY CARE ☐ ADULT DAY HEALTH CARE

42. MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

43. PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	44. SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED

NEW HAMPSHIRE VETERANS HOME
MEDICAL INFORMATION FORM

Name of Applicant _____ DOB _____ Social Security # _____

Immunizations: please provide dates of last administration
Tetanus Booster: _____ Pneumovax: dose 1 _____ dose 2 _____
Flu Shot: _____ Zostavax _____ Shingrix _____ Prevnar _____

Tuberculosis testing (required within 3 months of Application Date): Date _____
type of test (PPD, Quantiferon, etc.) _____ Results _____ (mm = _____)
Is Applicant free of communicable disease, including TB? _____ Yes☐ No☐
If no, explain: _____

Self Care Status:
Can applicant do the following:

	Yes	No
Dress self	☐	☐
Feed self without assistance	☐	☐
Use bathroom without assistance	☐	☐
Incontinent? Bowel	☐	☐
Bladder	☐	☐
Does applicant exit seek?	☐	☐

Diet Order:
_____

Activity Order:
_____

Mobility Status:
Ambulatory ☐ Cane ☐
Wheelchair ☐ Walker☐

Past History:	Yes	No	Year	Where Treated?
TB	☐	☐	_____	_____
Psychiatric Treatment *	☐	☐	_____	_____
*__Include Psych Consult, if applicable__				
Alcohol Abuse	☐	☐	_____	_____
Drug Abuse	☐	☐	_____	_____

Does the Applicant have the capacity to understand Health Care Issues?
Yes ☐ No ☐
Has the Durable POA for Health Care been activated?
Yes ☐ No ☐ Date:_____

Physician/ARNP Signature: _____ **Date of Exam:** _____
Physician's Name & Address (Print) _____
_____
_____
Phone: _____ Fax: _____

FOR NH VETERANS HOME PHYSICIAN ONLY
☐ Recommend for Admission ☐ Not Recommended for Admission
Signature _____ Date _____
Comments: _____
_____

NEW HAMPSHIRE VETERANS HOME
RELEASE OF INFORMATION

To: _____
(Name of medical provider, i.e. hospital, physician, rehab center, VA hospital, nursing home, VNA)

I, the undersigned, hereby authorize you to furnish a copy(ies) or allow a review of the medical record of:

_____	_____	_____
Name of Applicant	Date of Birth	SS #

Address:_____

City: State Zip Code: _____

Information requested is for the specific purpose of consideration for admission and for continued care if approved for admission to the New Hampshire Veterans Home:

- Discharge summaries for the past twelve months.
- Medical and psychiatric consults (including treatment of alcoholism/drug abuse) for the past twelve months.
- Chest x-rays and any laboratory results within the past 3 months.
- Immunization records.
- Primary care provider and consultant office notes for the past twelve months.
- Long term care facility medical records such as medication list, rehabilitation consults/ summaries, medical/psychological consults, social work assessments, diet, MD orders, nursing notes, lab results, X-rays, immunizations.
- Most recent DPOAHC and/or POA and/or guardianship documents

Please mail to: **Admissions Coordinator**
New Hampshire Veterans Home
139 Winter Street
Tilton, N.H. 03276

The information obtained herein is confidential, must be used solely for the purpose as stated, and may not be re-released. I also request that my consent become invalid one year from the date of signature. This authorization is subject to revocation at any time, unless action on it has already begun in good faith.

_____	_____
Applicant ☐	Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____	_____
Witness Signature (Required)	Date

NEW HAMPSHIRE VETERANS HOME
CONSENT TO TREATMENT, USE OF HEALTH CARE INFORMATION, AND RECEIPT OF PRIVACY NOTICE

Name: _____ Medical Record number: _____

_____ **(Please initial) 1. Consent for Care and Treatment**

I hereby authorize New Hampshire Veterans Home, its staff, practitioners, and others involved in the provision of services on its behalf, to examine me, secure appropriate information, and perform any routine treatment that may be appropriate for my condition. I understand that the practitioner or other responsible person will explain to me any particular treatment, including both its benefits and its risks, and that I have the right to refuse any proposed treatment.

_____ **(Please initial) 2. Consent to Use of Health Care Information**

I understand that New Hampshire Veterans Home will make use of my health care information for purposes of treatment and other lawful functions including securing payment and other usual healthcare operations. I understand that this information may be available to persons working on behalf of New Hampshire Veterans Home who will be subject to the same duty of confidentiality as New Hampshire Veterans Home with respect to my information. I understand that if the New Hampshire Veterans Home holds certain sensitive information related to my healthcare such as (i) records covered by federal law governing confidentiality of alcohol or drug abuse treatment programs; (ii) records covered by state rules governing the rights of recipients of mental health services; or (iii) records concerning my diagnosis or treatment for HIV infection, then my specific authorization will be required to disclose such information to others. However, I consent to the use of such information by New Hampshire Veterans Home for purposes of my evaluation and treatment. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

_____ **(Please initial) 3. Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge receipt of the New Hampshire Veterans Home Notice of Privacy Practices (effective date 04/05/2017). I understand this notice contains important information about how my medical information may be used and disclosed and how I can get access to this information

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____ _____

Witness Signature (Required) Date

New Hampshire Veterans Home
SECURITY FORM

Please read this form carefully and sign and date as instructed. Your witness does not have to be a Notary.

If you have ever been convicted of a crime (Felony or Misdemeanor) that has not been officially annulled by a Court, you **MUST** complete the following section, giving the date, location and nature of the Felony or Misdemeanor conviction.

If you leave this space blank, you are certifying that you have no current record of conviction.

_____

_____

_____

_____

_____

_____

Please note: Conviction is not an automatic disqualification for Admissions to the NHVH. Each case is considered individually. Willful omission or misrepresentation of required information may be a basis for rejection of your application to the NHVH.

_____ _____

Applicant ☐ Date

Authorized representative: Guardian ☐ DPOAHC ☐ Other (please specify) _____

_____ _____

Witness Signature (Required) Date

State of New Hampshire

Department of Safety
DIVISION OF STATE POLICE

Criminal Records Unit
33 Hazen Drive, Concord, NH 03305

CRIMINAL HISTORY RECORD INFORMATION RELEASE AUTHORIZATION FORM

INSTRUCTIONS

NH RSA 106-B:14 and Administrative Rule Saf-C 5700 authorizes the dissemination of NH Criminal History Record Information (CHRI) for non-criminal justice purposes. In NH, all CHRI is confidential and released only upon the knowledge and permission of the individual of whom the request is made. Individuals requesting their own record in person need only to complete Section I. If the CHRI is to be released to a third party, both Section I and Section II must be completed. All requests by mail must have both sections completed and Section II notarized.

SECTION I (PLEASE PRINT CLEARLY)

NAME_____
LAST (MAIDEN/ALIAS) FIRST MI

ADDRESS_____
STREET CITY STATE ZIP CODE

DATE OF BIRTH_____HAIR COLOR_____EYE COLOR_____

SEX____ DRIVER LICENSE NUMBER_____STATE____

PURPOSE OF RECORD: Housing Employment Annulment/Expungement

Other _____

My signature below certifies I am the individual listed above and the information provided is true

YOUR SIGNATURE: X_____ DATE_____
Signed under penalty of unsworn falsification pursuant to RSA 641:3

_____
SIGNATURE OF PERSON/ENTITY TO RECEIVE RECORD DATE

SECTION II

I hereby authorize the release of my criminal record conviction(s), if any, to the following individual:

New Hampshire Veterans Home
NAME OF PERSON/ENTITY TO RECEIVE RECORD

ATTN: Human Resources
ADDRESS 139 Winter Street, Tilton, NH 03276
STREET CITY STATE ZIP CODE

X_____
YOUR SIGNATURE DATE

_____
NOTARY'S SIGNATURE DATE
(AFFIX Seal) **(comm.. Exp.)**

RECORD CHALLENGE

Saf-C 5703.12 Procedure for Correcting a CHRI (a) Persons or their attorneys desiring access to their CHRI for the purpose of challenge or correction shall appear at the central repository. (b) A copy shall be provided to a person if after review he/she indicates he/she needs the copy to pursue the challenge. (c) Any person making a challenge shall identify that portion of his/her CHRI which he/she believes to be inaccurate or incorrect, and shall also give a correct version of his/her record with an explanation of the reason that he/she believes his/her version to be correct. (d) The director shall take the following actions within 30 days of receipt of challenge: (1) Review the records and contact the law enforcement agency or court which submitted the record to compare the information to determine whether the challenge is valid; (2) If the challenge is valid, which means there is a discrepancy between the information submitted and the information maintained by the law enforcement agency or court, the record shall be corrected and the person and appropriate CJAs shall be notified; and (3) If the challenge is invalid, the person shall be informed and advised of the right to appeal pursuant to RSA 541. (e) When a record has been corrected, the division shall notify all non-criminal justice agencies, to whom the data has been disseminated in the last year, of the correction.(f) The person shall be entitled to review the information that records the facts, dates, and results of each formal stage of the criminal justice process through which he passes, to ensure that all such steps are completely and accurately recorded.

WARNING: The Division of State Police is the Criminal Record Repository for the State of New Hampshire. The record you have received is based only on what has been reported to the Repository and may not be a complete Criminal History Record of the named individual.

☐ **To prevent a delay in processing, I have enclosed a self-addressed envelope.** ☐ **Prepaid Acc't Number**_____
(N/C State Agency)

A $25.00 fee is required for each request. Make checks payable to: State of NH – Criminal Records.

DSSP256 (Effective 7/15/16)

New Hampshire Veterans Home

Notice of Privacy Practices

Effective Date: 04/05/2017

This notice describes how your health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Introduction. The NH Veterans Home (NHVH) is required by law to maintain the privacy of your personal health information. We are now required by the Federal Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and HIPAA regulations, 45 CFR Part 160 and 164, to provide you with this Notice of Privacy Practices, our legal duties, and your rights concerning your health information. This Notice of Privacy Practices describes how the New Hampshire Veterans Home may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **Protected health information (PHI)** is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

II. Your Health Information Rights. While the actual records that we maintain about you belong to us, the information contained in our records belongs to you. Under the Federal Privacy Rules (45 CFR Part 160 and Part 164) you have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR Part 160.522
  Please note, however, that we are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your health information, we will notify you that your request for restriction will not be honored. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment.
- Obtain a paper copy of this Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your health record. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Amend your health record.
- Obtain an accounting of certain disclosures.
- Receive confidential communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Choose someone to act for you through an agent listed in your durable power of attorney over Health Care or a legal guardian. We will make sure this person has this authority and can act for you before we take action.
- File a complaint if you feel your rights have been violated by contacting us at the number listed at the end of this Notice. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

III. Our Responsibilities. New Hampshire Veterans Home is required to:

- Maintain the privacy of your health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Provide you with this Notice of Privacy Practices outlining our legal responsibilities and privacy practices.
- Abide by the terms of this notice. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Notify you if we are unable to agree to a requested restriction.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

IV. Examples of How We Will Use or Disclose Your Protected Health Information (PHI). The following are examples of the types and uses and disclosures of your PHI that we are permitted to make.

- **Treatment:** We will use and disclose PHI to provide, coordinate or manage your health care and any related services. For example, we may disclose your PHI to your primary care physician and to other physicians who may be involved in your health care. In addition, we may disclose PHI to other health care facilities that are providing your care such as hospitals and ambulance services to coordinate continuing care, diagnostic testing, surgery, therapy and other services.
- **Payment:** PHI will be used as needed to obtain payment for services that we provide to you. For example, we may disclose PHI to the Department of Veterans Affairs for benefits such as per diem payments, pharmacy and other medical benefits. We may disclose PHI to your health insurance company and its legal representatives.
- **Healthcare Operations:** We may use or disclose your PHI as needed to support our own business activities. These activities may include quality assessment and improvement, training and supervision of staff members or other business activities. We may share your PHI with other departments with the Home activities such as preparing and serving of meals, housekeeping and participation of recreational activities. For example, we may share your PHI with third party business associates that perform various services that are essential to our Home such as Physicians, Pharmacy, Dental, Rehabilitative and Speech Services. We will limit the amount of PHI that we provide to the minimum necessary to accomplish the particular task. We will have a written contract with business associates that contain terms that will protect the privacy of your PHI. We will use your PHI to provide you with appointment reminders and to discuss treatment options or other health related benefits that may be of interest to you.

V. Uses and Disclosures Not Requiring Your Authorization. The federal privacy rules provide that we may use or disclose your PHI without your authorization in the following circumstances (in accordance with applicable state and federal law):

- As required by law-to the extent that the use or disclosure is required by state or federal law
- Health Oversight Activities-in the context of audits, investigations, inspections and licensing activities
- Food and Drug Administration (FDA)- to report adverse events with respect to food, medications, products and product defects
- Public Health-to public health authorities charged with preventing or controlling disease, injury or disability

- Relating to Decedents -- regarding an individual's death, to coroners, medical examiners or funeral directors
- Organ/Tissue Donation -- if you are an organ donor, to assist in procurement, banking or transportation of donated organs or tissue
- Law Enforcement -- as required by law or in response to a valid search warrant or court order
- Legal Proceedings -- in response to an order of a court, subpoena, discovery request or other lawful process
- To Avert a Serious Threat to Health or Safety -- to warn of a resident's violent behavior when a resident has communicated a serious threat of physical violence against a reasonably identifiable victim
- Criminal Activity -- to law enforcement authorities if evidence of criminal conduct on our premises, to report suspected child abuse or neglect, or abuse of incapacitated adults or an injury that we believe may have been a result of an illegal act
- National Security and Intelligence Activities -- to authorized federal officers for national security activities.
- We can use or share your information for health research.

VI. Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law as described in this notice. You may revoke this authorization at any time in writing except to the extent that we have already relied upon your authorization in making a disclosure.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your name in a resident directory at the Receptionist's Desk for location in the Veterans Home unless you tell us you do not want that information in the directory.
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We never share or sell your information for marketing or fundraising purposes.

VII. Changes to the Terms of this Notice

We reserve the right to change our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain. Should our Notice of Privacy Practices change, we will notify you. The most up to date copy of this Notice of Privacy Practices will be displayed in prominent locations throughout the Home.

VIII. For More Information or to Report Complaints

If you wish to exercise any of the rights outlined in this notice or if you have questions and would like additional information, contact: **Laura Jackson Gaudette, Privacy Officer** at the New Hampshire Veterans Home, 139 Winter St., Tilton, NH 03276 (603) 527-4400.

If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer. If you are not satisfied with the Home's response, you may file a complaint with the Regional Office for Civil Rights. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint. To file a complaint with the government, contact:

Office for Civil Rights
Attn: Regional Manager
U.S. Department of Health and Human Services
JFK Federal Building Room 1875
Boston, MA 02203
(617) 565-1340
(617) 565-1343 (TDD)